Sutter Health
Palo Alto Medical Foundation

Pt sticker

Pregnancy Questionnaire

Name of Baby's Father/Significant Other:_____ SO's Phone Number:_____ (mobile)

OBSTETRIC HISTORY:

Pregnancies (Outcome is vaginal, C-section, miscarriage, abortion or ectopic)

	Date	Outcome	#weeks	Living	Birth Weight	Sex	Name	Hospital	Doctor	Epidural?
1										
2										
3										
4										
5										

GYNECOLOGIC HISTORY

Are you periods regular (monthly)? ☐Yes ☐No
Last pap test _____ Normal? ☐Yes ☐No
Did you have fertility treatment with this pregnancy? ☐Yes ☐No
If you took fertility medications, which one(s) did you take? _____

PAST OR CURRENT MEDICAL PROBLEMS:

Please check one	Yes	No	Please check one	Yes	No
diabetes	☐	☐	rheumatoid arthritis, lupus	☐	☐
high blood pressure	☐	☐	infertility	☐	☐
heart disease	☐	☐	urinary incontinence	☐	☐
varicose veins, blood clots in veins	☐	☐	uterine abnormalities	☐	☐
anemia, blood disorder	☐	☐	abnormal pap	☐	☐
neurological problem, seizures	☐	☐	trauma, violence	☐	☐
migraines	☐	☐	psychiatric problems	☐	☐
allergies, hay fever, chronic sinusitis	☐	☐	anxiety, panic attacks	☐	☐
autoimmune disease	☐	☐	depression, postpartum depression	☐	☐
hepatitis, liver disease	☐	☐	sexually transmitted disease	☐	☐
thyroid disorder	☐	☐	herpes	☐	☐
kidney or bladder disease	☐	☐	HIV	☐	☐
lung problem, asthma, tuberculosis	☐	☐	blood transfusion	☐	☐

SURGERIES AND APPROXIMATE DATES (month/year):

1._____ 3._____
2._____ 4._____

IMMEDIATE FAMILY MEMBERS WGO HAVE:

Diabetes_____ Any Cancer_____
High blood pressure_____ Thyroid issues_____
Heart attack/stroke_____ Mental health/ substance issues_____

SOCIAL HISTORY:

Currently or ever a smoker (including vaping) ☐Yes ☐No Current smoker Quit ____ (date)

Ever used recreational drugs including Cannabis/Marijuana? ☐Yes ☐No; Which drug(s) _____

Who lives at home with you?_____

Has your partner ever hit you, kicked you or threatened to harm you? ☐Yes ☐No

Do you own cats? ☐Yes ☐No

What is your occupation?_____

Are you exposed to any occupational chemicals? ☐Yes ☐No; Which chemical(s) _____

PRENATAL GENETIC SCREENING:

Mother of Baby
Is your ancestry:

- ❑ African American
- ❑ French Canadian
- ❑ Jewish
- ❑ Italian, Greek, Middle Eastern
- ❑ Asian
- ❑ Hispanic
- ❑ Filipino
- ❑ Other_____

Father of Baby
Is his ancestry:

- ❑ African American
- ❑ French Canadian
- ❑ Jewish
- ❑ Italian, Greek, Middle Eastern
- ❑ Asian
- ❑ Hispanic
- ❑ Filipino
- ❑ Other _____

INFECTION SCREENING:

	Yes	No	Don't Know
Do you live with someone with TB or have you been exposed to TB?	☐	☐	☐
Do you or your partner have genital herpes?	☐	☐	☐
Have you had a rash or viral illness since your last period?	☐	☐	☐
Have you had Gonorrhea, Chlamydia, HPV or Syphilis?	☐	☐	☐
Have you traveled outside the continental U.S. at any time during or 6 months before your pregnancy?	☐	☐	☐

**Is there anything confidential you would like to discuss in private with your physician? _____

_____

Signature_____ Date_____